Response to:
SOLICITATION NO. RFP-DCS-1257606

Outreach Navigation Program

City and County of Honolulu
Department of Community Services

Submitted by:

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Tab 1 Outreach Navigation Program Operational and Administrative Plans

1.Operational and Administrative Plans for a 1-Year Term

Founded in 1978, IHS, The Institute for Human Services, Inc. has over 40 years of experience serving unsheltered and sheltered homeless persons and helping them to transition into needed treatment services, shelter and stable housing. Over four decades of serving homeless and at-risk households through outreach, shelter, housing placement, and other support services, our service structure and delivery has become attuned to the needs of different populations across the island, particularly those who are Chronically Homeless and suffering from serious mental illness and/or substance use disorder. This project builds on IHS' several years of advocating for ACT order legislation, interfacing with medical and legal providers to streamline ACT order processes, and filing petitions for ACT orders for homeless adults we serve who are most in need of treatment.

The $500,000 in annual funding support requested through this proposal will support IHS' administration and management of the Outreach Navigation Program which will serve a focus population of Chronically Homeless persons with serious mental illness who are treatment resistant and reside on Oahu. IHS and partner medical practitioner staff will outreach the target population, locate and engage clients to build trust and rapport, assess and evaluate medical and psychiatric needs, develop and implement treatment and case management plans, file ACT orders when appropriate and conduct follow up treatment and case management services to achieve the RFP's five core goals and objectives:

1. To conduct outreach work to locate and identify Chronically Homeless persons with mental illness and/or substance use disorder who are service resistant.
2. Assess and evaluate the medical and psychiatric needs of these persons.
3. In collaboration with medical practitioners, develop and implement Treatment and Case Management Plans for Clients.
4. In collaboration with medical practitioners and attorneys, file for ACT orders, as appropriate, and if granted, implement Treatment and Case Management Plans.
5. Create partnership agreements, subcontractor agreements, and/or Memoranda of Agreement/Understanding with medical practitioners, attorneys, and government agencies/programs to support ACT orders.

Service projections for Year 1 are for 100 clients to be referred, outreached and assessed for ACT order eligibility, file 40 petitions for ACT orders, and 30 ACT orders and guardianships to be obtained.

a. Logic Model and Operational Plan-Outreach Navigation Program Year 1

IHS will be responsible for all aspects of Outreach Navigation Program operations and management. The Logic Model below shows overall organization of project resources, activities, outcomes, and strategic goals. The Operational Plan below details the program's operating schedule, while the administrative plan outlines key program administrative tasks and functions.

Logic Model

Resources (Inputs)	Program Components (Activities)	Outputs (Objectives)	Outcomes (Goals)
•City Officer-in-Charge •IHS Outreach Team •IHS Outreach Navigation Program Coordinator	Via general and targeted outreach, assess reported areas to identify and locate focus population Receive and prioritize referrals from other providers, public.	Year 1: 100 clients referred to Outreach Navigation Program	Goal 1. Conduct outreach work to locate and identify CH persons with MI and/or SUD who are service resistant.
•IHS Outreach Staff •Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa	Outreach identified individuals, gain rapport and trust	Year 1: 100 clients outreached by program	

•IHS Outreach Staff •Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa •Legal Services providers IHS Outreach Staff Medical Practitioners •IHS Outreach Staff •Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa	Client Psychiatric Evaluations to determine if clients meet ACT order criteria Clients below ACT criteria: Determine if client in need of further medical/psychiatric tx, Develop Tx and CM Plan Clients meeting ACT criteria: Develop Tx and CM Plan, attend court hearings If order granted, Medical Practitioner oversees implementation of Tx and CM Plan If order not granted: Determine if client in need of further medical/psychiatric tx, Develop Tx and CM Plan If indicated, recommend contacting APS and/or OPG	Year 1: 100 clients evaluated for ACT criteria If existing BH CM present, enlist CM and CM Team psychiatrist into ACT determination process Year 1: 40 ACT order petitions submitted to Family Court Year 1: 30 ACT orders and guardianships obtained in the course of year.	Goal 2. Assess and evaluate the medical and psychiatric needs of these persons. Goal 3. In collaboration with Medical Practitioners, develop and implement Treatment and Case Management Plans for Clients.

•IHS Clinical Director •Medical Practitioners •Legal Services partners •IHS Director of Community Relations and Development	Develop and file petitions in Family Court to request ACT order for clients who meet ACT criteria Ongoing recruitment of lawyers to assist with ACT petitions Presentations at UH Law School; kick-off presentation in October 2019, quarterly thereafter	Year 1: 40 ACT order petitions submitted to Family Court Secure lawyers who are interested in assisting with ACT petitions Provide training and support to lawyers recruited	Goal 4. In collaboration with Medical Practitioners and attorneys, file for ACT orders, as appropriate, and if granted, implement Treatment and Case Management Plans. Goal 5. Create partnership agreements, subcontractor agreements, and/or MOAs/MOUs with Medical Practitioners, attorneys, and government agencies/programs to support ACT orders.
•Leveraged IHS case managers: ADAD, AMHD, CCS •Leveraged IHS outreach workers: HPO, AMHD, ADAD •Other POS CMs from other agencies	Provide case management for clients identified for treatment and CM plans, based on eligibility	Provide case management for clients identified as being in need based on goal of obtaining medical and/or psychiatric treatment(s)	Goal 4. In collaboration with Medical Practitioners and attorneys, file for ACT orders, as appropriate, and if granted, implement Treatment and Case Management Plans.

•Leveraged IHS shelter, meal program, shelter staffing, health services staffing: Kaaahi ES Sumner ES Hale Mauliola ES TBH1/2/3 KURH	Provide bridge shelter placement via emergency and specialty shelter beds for clients entering into treatment who are amenable to bridge placements	Provide for basic shelter, personal safety, food, hygiene, and social support needs temporarily while treatment is initiated and coordinated entry for housing is conducted	Based on client preference and willingness; brokered by outreach workers in partnership with Clinical Director
•IHS Executive Director, IHS Director of Community Relations and Development	Develop inventory of treatment beds for ACT order clients to accommodate increased demand resulting from the program	Treatment beds are essential for ACT order to be effective; in absence of an appropriate bed, ordered treatment cannot take place.	Provide key needed treatment facilitation resources currently under-stock in the community.
•IHS Executive Director, IHS Director of Community Relations and Development	Develop inventory of bridge placement options for participants.	Bridge placements are essential to meet basic needs of client participants; in interim, IHS shelters are options.	Provide bridge housing for smooth transition from treatment into housing.

Reporting/Data Quality •Outreach Navigation Program Coordinator •Director of Programs & Evaluation •Data Specialist	Monitor recording and collation of monthly data: -# Clients evaluated meeting ACT criteria -# Clients not meeting ACT criteria -# ACT petitions filed and awaiting order -# Clients received medication through ACT orders -Other services provided to project clients as recommended by Tx and CM Plans -#Clients transitioning into shelters, temporary housing, and permanent housing through Program services	•Timely and accurate tracking of program outcomes	•Maintain timely, accurate program data

Program Activities and Fiscal Reporting/City Stakeholder Relations <u>Key IHS Staff</u> •Data Specialist •Director of Programs & Evaluation •Director of Finance and Finance staff	Reporting: •Monthly and annual activities and fiscal reporting to City. •Other City data requests. •Fiscal control and oversight •Notify City when Program funds are 75% drawn	•Monitor client volume and rate of movement through service phases •Monitor service utilization trends. •Monitor project financials and fiscal progress relative to budget.	•Facilitate and adjust tactical activities as needed to ensure target service volume and rate delivered

Operational Plan

Activities	Specific Tasks, Related Work Assignments & Responsibilities	Staff Responsible	Timeline/ Schedule
-Determine locations and frequencies for routine and targeted outreach rounds to surface target population on Oahu	-Triangulate locations of focus population through direct observation, reports from partners and information from community stakeholders	-City Officer in Charge IHS Executive Director Outreach Program Manager -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa -Other referral sources	-Ongoing, throughout contract -May shift if population concentrations shift

-Outreach identified individuals, gain rapport and trust -Identify ACT order candidates	-Via repeated encounters, build familiarity with target population individuals -Develop working rapport	-IHS Outreach Staff -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa Other referral sources	-Through recurring weekly rounds and via targeted outreach rounds.
-Conduct Client Psychiatric Evaluations to determine if clients meet ACT order criteria	-Via field-delivered assessments, evaluations at IHS offices, other data sources	-IHS Outreach Staff -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa Other referral sources	-Ongoing, throughout contract
-Clients below ACT criteria: Determine if client in need of further medical/psychiatric tx, Develop Tx and CM Plan	-Determine continuing care needs and follow-on services for sub-ACT criteria clients	-IHS Outreach Staff -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa Other referral sources	-Ongoing, throughout contract
-Clients meeting ACT criteria: Develop Tx and CM Plan, attend court hearings	-For those meeting ACT criteria w/o behavioral health CMs -For those with behavioral health CMs, link with CM and enlist CM and team psychiatrist's assistance in completing ACT petition	-IHS Outreach Staff -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa -Other referral sources	-Ongoing, throughout contract
-Develop and file petitions in Family Court to request ACT	-For those meeting ACT criteria	-IHS Clinical Director -Medical Practitioners -Legal Services partners	-Ongoing, throughout contract

order for clients who meet ACT criteria			
-If ACT order granted, Medical Practitioner oversees implementation of Tx and CM Plan	-If ACT order granted	-IHS Outreach Staff -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa -Other referral sources	-Ongoing, throughout contract
-If ACT order not granted: Determine if client in need of further medical/psychiatric tx, Develop Tx and CM Plan	-If order not granted and if team decides not to re-file ACT petition	-IHS Outreach Staff -Medical Practitioners Dr. Koyanagi, APRN-Rx Tanigawa -Legal Services provider -Other referral sources	-Ongoing, throughout contract
-If indicated, recommend contacting APS and/or OPG	-Based on evaluation of team	-IHS Clinical Director -Medical Practitioners -Legal Services provider	-Ongoing, throughout contract
-Case Management	-Provide case management according to client's plan with objective of linking client to needed medical and/or psychiatric treatment(s)	-IHS Outreach workers, AMHD Interim, ICM Plus Homeless, CCS, ADAD care coordination, and other community case management providers	-As required by each client's Treatment Plan and Case Management Plan; based on service eligibility

-Other Support Services	-Includes but not limited to IHS and partner agency health and medical services, psychiatry, substance abuse, veterans, housing placement, employment, and other support services.	-IHS Housing, Employment, Health Services -Other community providers	-Vary by service and client's need level.
-Program fiscal management	-Ensure activities conducted within budget. -Approve and monitor project fiscal activities. Request budget revision if needed with City -Report when funds 75% drawn.	-IHS Finance staff	-Monthly reports and invoicing. -Monthly expense reports against budget
-Program activity and fiscal reports	-Data collection, quality assurance, and analysis. -Monthly reports and billing submitted timely. -Other required reports submitted timely (e.g. annual report) -Monitor service utilization trends, progress towards outcomes.	-IHS Finance Staff -Director of Programs & Evaluation. Data Specialist	-Monthly reports -Annual project report Other City requested reports

b. Administrative Plan-Outreach Navigation Program Year 1

Objectives & Major Tasks	Position	Targets	Frequency
-Notify project staff, prepare for, and hold project convocation meeting. -Hire Outreach Program Coordinator -Finalize MOUs/MOAs, invoicing, documentation, reporting	-IHS Executive Director, Clinical Director, Outreach Team, Finance staff -IHS Human Resources -Medical Practitioners -Legal Services partners	All core project staff appraised of contract requirements, roles, responsibilities, and timelines. -Convocation completed Month 1, Year 1 -Onboard Outreach Program Coordinator to team.	-Month 1, Year 1. -Month 1, Year 1; annually thereafter. -As needed.
-Commence full program services	-IHS Executive Director, -Clinical Director, -Outreach Team -Medical Practitioners -Legal Services partners	-Immediately upon NTP.	-Upon NTP, annually.
-Ongoing documentation review	-Clinical Director -Director of Clinical Program Administration -Outreach Program Coordinator -Medical Practitioners	-Ongoing review of referrals, referral clearing, progress notes, case management and treatment plans	-Ongoing, throughout program
-Monthly invoicing by subcontractors	-IHS Finance staff -Medical Practitioners	-Submitted timely w/ required supporting documentation.	-Monthly, throughout program

	-Legal Services Partners		
-Monthly activity and financial reports of	-Director of Programs & Evaluation, Data Specialist, Finance staff	-Submitted as required contractually. -IHS understands reporting requirements may change over time	-Monthly, close of year, as otherwise requested

2. Policies and Procedures for Determining Target Areas and Persons

There are five major expected sources of referrals of persons from the target population for project services: 1) Clients identified through efforts conducted prior to project inception, 2) Clients encountered by IHS' Outreach Team during routine outreach rounds, 3) Clients referred by other outreach teams and homeless service provider organization such as H4, 4) Clients referred by the general public through the IHS Help Homeless hotline, and 5) Clients referred through the City Officer in Charge, State, TheBus, private business owners, HPD community policing teams, and identified through Queen's Care Coalition. This method capitalizes on the number of proverbial "eyes on watch" and "boots on the ground" from partners who are already providing actionable intelligence to IHS outreach on the location of vulnerable homeless persons, making our outreach encounters better prepared, more informed, and more efficient.

At the time that this proposal is being written, IHS has been pursuing ACT orders for several years. There are clients already identified through outreach that have been added to a list of persons who we believe are in need of psychiatric medication and who may well be eligible for ACT. We will also ask HPD Precincts in Urban Honolulu and Windward Oahu whom we work with routinely to make referrals of mentally persons who are repeatedly arrested and appear to meet criteria for ACT. Thusly, it is likely that when the program starts, there will already be a lengthy list of clients to be evaluated for Outreach Navigation Program services.

Excluding special field rounds with other agencies and as parts of larger partnerships, IHS outreach typically conducts 22 field rounds per week comprising 9 field rounds in Urban Honolulu, 7 in East Honolulu/Waikiki, 4 in Windward Oahu, and 2 at the Chinatown Joint Outreach Center. Rounds are conducted at different times of day, and structure depends on primary mission objective (e.g. case finding a newly referred person vs. follow routine follow up on benefits application vs. transportation to clinic for appointment.) When initial referral data does not clearly suggest severe mental illness or behavior suggestive of chronic Substance Use Disorder, outreach staff will conduct face to face interactions to confirm symptom and behavioral evidence prior to targeted deployment of a medical practitioner. In some cases, this may take several series of outreach rounds for determination.

A Medical Practitioner will be embedded with the team when targeting clients who are candidates for ACT orders, allowing the psychiatrist to meet with the client face to face, make some determinations regarding the client's condition, and complete preliminary assessment and evaluation tasks. Upon conclusion of the field round, the psychiatrist debriefs with the rest of the team to determine next steps required, timelines, and preparations that need to be made in advance of the next field session. It is expected that a Medical Practitioner will go the field on outreach an average of two times per week. This will likely decrease later in the program year when there are more clients being "carried" through the program due to receiving case

management and being active in services, which will involve the Medical Practitioners providing more treatment services and less outreach, assessment, and evaluation. Medical Practitioners may be required to deploy to the field at a greater frequency if warranted by referral volume, total volume of clients being served with treatment and case management, and total clients in ACT petition and current ACT order status.

Finally, for those instances where the client has an existing behavioral health case manager and an ACT order is needed, we propose that case management be provided by the client's existing case manager and that our team will facilitate the ACT petition process using the client's existing psychiatrist (all behavioral health case management teams have a team psychiatrist, even if the client is refusing or otherwise not active in treatment. This will grow community capacity to effectively conduct ACT orders and additionally prevent duplication of case management and psychiatric resources.

3. Fielding and Prioritizing Referrals

Referral and reports of persons experiencing Chronic Homelessness who have mental illness and/or SUD and who are service resistant for the Outreach Navigation Program will be consolidated by the Outreach Navigation Coordinator, providing a single responsible entity for tracking a client's progress through the program's service phases. Referrals will be classified by geographical region and existing data reviewed to determine if the person who is the subject of the referral is already known to the team (or already in que for program services).

The team will interface with the referring party, to the extent possible, to determine the client's location, identifying features (preferably a photograph), any historical information and behavioral observations as well as determining if any gatekeepers are present (e.g. known relatives, outreach worker or case manager, park worker) who can broker introduction and supply information. We generally research whether an individual has family interested in being involved or would at least indicate no objection as required for filing guardianship or ACT. Our experience is that having family members involved has allowed us to pursue guardianship more easily in some cases. If a behavioral health case manager is present, the team will connect with the client's case manager. If an ACT order is warranted, then the team will facilitate that process with the client's existing case manager and case management team psychiatrist.

Clients referred will be prioritized for follow up based on order of referral receipt, urgency (e.g. data suggest deterioration of condition and inability for self-care), and actionability (e.g. photo received, location is known, and behavior clearly suggestive of serious mental illness and/or substance use disorder). To the extent possible, initial outreach (if not already executed) will be carried out through routine outreach rounds to make face to face contact with the client. Outreach workers will ascertain and document basic mental status, behavioral observations, and

presentation while engaging and building rapport and starting inquiry into Chronic Homeless status. VI-SPDAT scores may offer some indication of an individual's vulnerability and offer a basis for validation. In instances where behavioral data clearly supporting presumed serious mental illness or SUD is present in the referral information, one of the project Medical Practitioners may deploy to the field with the outreach team for initial engagement.

Data collected during initial engagement will be used by the Medical Practitioner to determine if the client is in need of treatment, a candidate for ACT order, or if more data is required to make theses determinations. If it is determined that the client requires treatment or is a candidate for an ACT order, the Medical Practitioner and team will begin a treatment plan and case management plan for the client which will detail services goals, interventions, timelines, responsible parties. Outreach workers, Medical Practitioners, Case Managers, and other staff will document client encounters through written progress notes using the standard DAP format.

4. Treatment and Case Management Plans

IHS proposes to use our current Master Treatment Plans already in use with our clinical case management teams serving behavioral health consumers. See attached sample in **Sample Treatment and Case Management Plan** in the Supplemental Pages following this section.

Services that may be recommended, offered, or to which the client may be referred to as part of the client's treatment plan are those which are the most appropriate to the client's assessed needs and to which the client is most ready and amenable to participate in. Thusly, while there are common service domains that all clients have in common, prioritization, degree of assistance required, and specific types of programming and intensities will vary based on the needs of each individual served. Key to addressing any client needs dimension effectively is the capability of the service team to assess the client's current readiness to change, active change drivers, factors likely to sustain motivation to change, and continuing, consistent delivery of appropriate motivational enhancement by the team to maintain momentum, support the client through slips, and build new behavioral tools and coping skills. For those clients with an existing community behavioral health case manager, the IHS team's plan will focus on obtaining the ACT order, while the community case manager will focus on the continuing care and service/resource linkage aspects.

The most common service domains in case management plans include:

1. Crisis Planning: Identify past crisis situations, precipitants, and interventions and supports that were and were not successful. Crisis situations may include but are not limited to suicidal/homicidal ideation, plans, and attempts; perpetration of or victimization via violence, resumed drug/alcohol use, domestic violence, and other situations. With the consumer, the team identifies plan of action, desired supports, treatments, and providers in event of recurrence of

crisis situation. Referrals may include Crisis Line of Hawaii, Crisis Mobile Outreach, LCRS, medical and psychiatric providers, emergency services (police/fire/ambulance), community case manager, AA/NA/other peer organization sponsor, case manager, and faith community representative (if desired by the client, e.g. rabbi, priest, minister).

2. Psychiatric Stability: This dimension addresses ensuring that clients are linked with psychiatric evaluation, follow on care, and medications to treat for the psychiatric symptoms the client is experiencing. Potential referrals include team Medical Practitioners, LCRS, IHS KURH Specialty Shelter, Inpatient Psychiatric Treatment, and outpatient services. If the client does not have insurance, Medicaid application and evaluation for other health insurance benefits needs to take place. Other support services include medication coaching, symptom education, psycho-social rehabilitation, and referral for AMHD or CCS Case Management to assist the client in maintaining treatment linkage if the client is eligible. Interventions may include hospital admission by the medical practitioner.

3. Medical Stability: Ensure that client has medical insurance and is linked with needed routine screening, health evaluation and follow up care. Referral to primary/specialty care; advocate for Medical Care Coordinator/chore worker/home nursing assistance (if needed and client is eligible through health insurance plan); Refer for medication coaching, symptom education. Refer to APS and/or OPG if needed due to incapacity for self-care or self-neglect (e.g. resulting in malnutrition, dehydration, festering wounds, etc.)

4. Vocational/Benefits/Financial Stability: Apply directly for General Assistance cash, food, and Medicaid/Medicare benefits for which the client is eligible; refer to Legal Aid for assistance with SSI, SSDI, VA claims/reinstatement; refer to IHS Hele2Work vocational program; refer to America's Job Center. May also include Medicaid health plan funded employment navigation services if eligible through health plan.

5. Substance Abuse Treatment and Sobriety: May include referral to social/medically monitored detoxification (e.g. Salvation Army Detox), 12-step and other peer lead programs (e.g. AA, NA, Rational Recovery), specialized opiate program (e.g. CHAMP, Ku Aloha Ke Ola Mau), substance abuse assessment for treatment placement (e.g. Hina Mauka, Salvation Army ATS, Hoomau Ke Ola, Queen's Day Treatment Services, Poailani), addiction care coordination (via ADAD) and addictions psychiatry/medication assisted treatment services.

6. Legal Stability: Comprises assisting the client with stabilizing any civil or criminal legal issues. Examples include unpaid parking/jaywalking tickets, eviction, supervised release, probation and parole. Referrals may include referring the client to Legal Aid for assistance, supporting the client to interface effectively with his/her probation officer, facilitating payment of court fees and fines, and supporting the client in accessing services that are part of his/her

terms of release (e.g. obtain substance abuse assessment, participate in HOPE urinalysis hotline, adhere to residence requirements and curfew hours, obtain employment, etc.)

7. Housing Stability: This dimension addresses the fundamental goal of client entering into and maintaining tenure in stable housing meeting his or her needs. Referrals may include VI-SPDAT and CES consent completion to ensure Coordinated Entry is effected, follow up on CES mediated housing program referrals (e.g. Housing First, Permanent Supportive Housing, Rapid Rehousing), and when appropriate, referral for and assistance with clean and sober, foster, group home, and other specialized living placements.

8. ADL/Life Skills Development and Stability: This dimension addresses the client's capacity to engage in Activities of Daily Living (ADLs) and other critical life skills. Examples include personal budgeting, shopping for groceries, paying bills, laundry, housekeeping, using domestic appliances safety (e.g. washer, dryer, stove), troubleshooting common tenancy problems (e.g. clogged drain or toilet), using public transportation, attending needed appointments, and maintaining personal hygiene. Possible referrals include IHS Life Skills groups held at the shelters, Peer Coach programs, and other community groups.

9. Establish healthy personal lifestyle: This dimension addresses basic client wellness in the areas of risk management, nutrition, and exercise. Examples of referrals may include those derived by the client's PCP/specialist for exercise and wellness programs through their insurance plan, participation in community nutrition education programs, or joining a canoe club.

10. Basic needs: This dimension addresses the client being able to access to resources meeting basic needs of personal safety, food, clothing, and shelter. Referrals may include community food banks, free meal resources (including IHS meals), IHS and other shelters, and clothing banks,

11. Building healthy social supports: This dimension comprises re-building and establishing supportive social ties with pro-social supports. Examples include reuniting with children and other family members and old friends, connecting with faith communities, and re-engaging in recreational activities that the client had enjoyed during better times in his or her life. Examples of referrals may include arts and crafts classes taught at community centers, 12-step and faith community support groups, United Self Help, and others.